XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LISA MARIE GAIL, P.A.** 5125 Bering St., NW Gig Harbor, WA 98332 Physician Assistant License No. PA 21808, Respondent.	Case No. 950-2016-001103 **ACCUSATION**

Complainant alleges:

PARTIES

1. Maureen L. Forsyth ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs ("Board").

2. On or about September 7, 2011, the Physician Assistant Board issued Physician Assistant License Number PA 21808 to Lisa Marie Gail, P.A. ("Respondent"). That license was

///

in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 3504 of the Code provides in pertinent part for the existence of the Physician Assistant Board within the jurisdiction of the Medical Board of California.

5. Section 3528 of the Code provides in pertinent part that any proceedings involving the denial, suspension or revocation of the application for licensure or the license of a physician assistant, the application for approval or the approval of a supervising physician, or the application for approval or the approval of an approved program under this chapter shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

6. Section 3527[1] of the Code states, in pertinent part:

"(a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

"(b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.

///

[1] Effective: January 1, 2013. The previous language of section 3527, as set forth between January 1, 2008, to December 31, 2012, underwent stylistic changes but no substantive changes occurred.

"(c) The Medical Board of California may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

"(d) Notwithstanding subdivision (c), the Division of Medical Quality of the Medical Board of California, in conjunction with an action it has commenced against a physician and surgeon, may, in its own discretion and without the concurrence of the Medical Board of California, order the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

"...

"(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

"(g) The expiration, cancellation, forfeiture, or suspension of a physician assistant license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license."

7. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

///

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care."

"..."

8. Section 2242 of the Code states, in pertinent part:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"..."

9. Section 2266 of the Code states, in pertinent part:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. California Code of Regulations, title 16, section 1399.521 states, in pertinent part:

"In addition to the grounds set forth in section 3527, subdivision (a) of the Code, the committee may deny, issue subject to terms and conditions, suspend, revoke, or place on probation a physician assistant for the following causes:

"(a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon."

"...

"(d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in the regulations."

COST RECOVERY

11. Section 125.3 of the Code states:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

"(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

"(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

"(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

"(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licentiate to pay costs.

///

"(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

"(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licentiate who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licentiate who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

"(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

"(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

"(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

"(k) Notwithstanding the provisions of this section, the Medical Board of California shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licentiate. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435."

PERTINENT DRUG INFORMATION

12. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride ("hcl") is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a

///

dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

13. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

14. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Morphine sulfate – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse

and can lead to addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of more times more potent than heroin.[2] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (c).

17. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting semi-synthetic opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055 subdivision (b).

18. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[3] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

19. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

///

---

[2] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

[3] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

20. Codeine with Acetaminophen – Generic name for the drugs Tylenol with Codeine #3 ("Tylenol #3") and Tylenol with Codeine #4 ("Tylenol #4"). Codeine is an opioid pain medication used to treat mild to moderate pain. As with other opiate-based painkillers, chronic use of codeine can cause physical dependence. Codeine with acetaminophen is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13, subdivision (e). Codeine with acetaminophen is a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e).

21. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. On January 11, 2012, Carisoprodol was classified as a Schedule IV controlled

///

substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

25. Zolpidem tartrate – Generic name for Ambien. Zolpidem tartrate is a sedative and hypnotic used for short-term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

26. Respondent's license is subject to disciplinary action under sections 2234, subdivision (b), 3527, and 3528, in that she committed gross negligence during the chronic pain management care of Patients A, B, and C[4]. The circumstances are as follows:

27. Respondent is a licensed physician assistant. During the care and treatment of Patients A, B, and C, as described in the Accusation, Respondent was working under the supervision of Physician 1 in a facility operated by Rideout Clinic, located in Grass Valley, California.

Patient A

28. On or between February 25, 2015, and March 17, 2017, Respondent prescribed a series of controlled substances to Patient A including, but not limited to, carisoprodol, hydrocodone with acetaminophen, tramadol, zolpidem tartrate, diazepam, codeine with acetaminophen, hydromorphone hydrochloride, and oxycodone. These medications were often prescribed in combination with each other and a review shows that Respondent steadily increased Patient A's morphine equivalent dose[5] over time as she prescribed opiates and opioids.

[4] All witnesses will be fully identified in discovery. Patient names have been removed to protect their confidentiality.

[5] Morphine Equivalent Dose ("MED"), An MED is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg. per day. http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17.

29. By way of example, the following prescriptions were written by Respondent and filled by Patient A, between May 4, 2016, and June 29, 2016.

Date Prescription Filled	Type of Prescription	Dosage of Prescription	Quantity of Prescription	Schedule of Prescription	Refills
5/4/2016	Ambien	5 mg.	30 TAB	IV	yes
5/4/2016	Ultram	50 mg.	56 TAB	IV	0
5/4/2016	Norco	10/325 mg.	39 TAB	II	0
5/4/2016	Tylenol #4	300/60 mg.	14 TAB	III	0
5/11/2016	Ultram	50 mg.	56 TAB	IV	0
5/11/2016	Tylenol #4	300/60 mg.	14 TAB	III	0
5/11/2016	Norco	10/325 mg.	39 TAB	II	0
5/18/2016	Tylenol #4	300/60 mg.	60 TAB	III	0
5/20/2016	Ultram	50 mg.	112 TAB	IV	0
5/20/2016	Norco	10/325 mg.	78 TAB	II	0
6/1/2016	Ultram	50 mg.	112 TAB	IV	0
6/6/2016	Tylenol #4	300/60 mg.	12 TAB	III	0
6/6/2016	Valium	5 mg.	27 TAB	IV	0
6/8/2016	Tylenol #4	300/60 mg.	14 TAB	III	0
6/8/2016	Norco	10/325 mg.	45 TAB	II	0
6/15/2016	Norco	10/325 mg.	45 TAB	II	0
6/15/2016	Ultram	50 mg.	112 TAB	IV	0
6/15/2016	Tylenol #4	300/60 mg.	14 TAB	III	0
6/15/2016	Ambien	5 mg.	30 TAB	IV	yes
6/22/2016	Tylenol #4	300/60 mg.	14 TAB	III	0
6/22/2016	Norco	10/325 mg.	45 TAB	II	0
6/29/2016	Ultram	50 mg.	60 TAB	IV	0

6/29/2016	Norco	10/325 mg.	44 TAB	II	0
6/29/2016	Tylenol # 4	300/60 mg.	14 TAB	III	0

30. Between May 1, 2016, and July 4, 2016, or a total of 65 days, Patient A received an approximate total of 156 tablets of Tylenol #4, 508 tablets of Ultram, 335 tablets of Norco, 27 tablets of Valium, and 60 tablets of Ambien from Respondent. The approximate MED per day at that time was 118 from these three short acting opioid medications while in combination with a benzodiazepine and a hypnotic.[6] On or about July 19, 2016, Respondent added Dilaudid to Patient A's treatment. On or about September 28, 2016, Respondent added oxycodone to Patient A's treatment. Respondent had previously prescribed carisoprodol to Patient A in February 2015.

31. By way of example, the following prescriptions were written by Respondent and filled by Patient A, between November 22, 2016, and January 3, 2017.

Date Prescription Filled	Type of Prescription	Dosage of Prescription	Quantity of Prescription	Schedule of Prescription	Refills
11/22/2016	Oxycodone	20 mg.	21 TAB	II	0
11/22/2016	Dilaudid	4 mg.	42 TAB	II	0
11/22/2016	Soma	350 mg.	60 TAB	IV	0
11/30/2016	Oxycodone	20 mg.	28 TAB	II	0
11/30/2016	Dilaudid	4 mg.	28 TAB	II	0
12/7/2016	Oxycodone	20 mg.	28 TAB	II	0
12/7/2016	Dilaudid	4 mg.	28 TAB	II	0
12/13/2016	Ambien	5 mg.	30 tablets	IV	yes
12/14/2016	Oxycodone	20 mg.	28 TAB	II	0
12/14/2016	Dilaudid	4 mg.	48 TAB	II	0
12/20/2016	Oxycodone	20 mg.	28 TAB	II	0
12/20/2016	Dilaudid	4 mg.	28 TAB	II	0
12/22/2016	Soma	350 mg.	60 TAB	IV	0
12/27/2016	Tylenol #4	300/60 mg.	4 TAB	III	0

[6] http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

12/28/2016	Oxycodone	20 mg.	28 TAB	II	0
12/28/2016	Dilaudid	4 mg.	28 TAB	II	0

32. Between November 22, 2016, and January 3, 2017, or a total of 43 days, Patient A received an approximate total of 161 tablets of oxycodone, 202 tablets of Dilaudid, 30 tablets of Ambien, 120 tablets of carisoprodol, and 4 tablets of Tylenol #4. The approximate MED per day at that time was 174 from the two opioid medications in combination with a hypnotic and a muscle relaxant. Respondent had also prescribed 6 tablets of Valium on or about November 8, 2016 to Patient A.[7]

33. On or about February 25, 2015, Respondent began providing treatment to Patient A and saw her for a controlled substances refill. Respondent's supervising physician had previously seen Patient A at the clinic. Patient A reported that her back pain was generally better but that she reported intermittent lumbar pain. Current treatments were listed as NSAIDS,[8] physical therapy, muscle relaxer, and pain management. Patient A reported that she had migraines twice a month and reported "pain down her arm". She reported taking Flexeril, Zofran, Prozac[9], gabapentin, trazodone[10], Topamax, Ultram, Fiorinal, Ambien, Restoril, and Trazodone. Physical examination included normal vital signs and the back exam showed a "tightness of PVM's" which presumably referred to paravertebral muscles. Respondent assessed Patient A as having low back pain, migraine headaches, insomnia, depressive disorder, myalgia and myositis, and headache. The plan was for Patient A to receive Norco 10/325 mg., 150 tablets, and, Flexeril[11] 5 mg., 1-2 tablets at bedtime.

///

---

[7] Between November 30, 2016, and, March 15, 2017, it appears that every seven days, Patient A filled a prescription for 28 tablets of 20 mg. oxycodone and 28 tablets of 4 mg. Dilaudid. Assuming that Patient A consumed 112 tablets of oxycodone and 112 tablets of Dilaudid as prescribed every twenty-eight days the MED per day would have been approximately 184. Respondent was still prescribing Soma and Ambien to Patient A.

[8] Non-Steroidal Anti-inflammatory Drugs. Common over-the-counter ("OTC") medications include naproxen and ibuprofen.

[9] Fluoxetine (Prozac) is a selective serotonin reuptake inhibitor used to treat depression.

[10] Trazodone (Desyrel) is an antidepressant medication. This medication is also used in low doses to help patients with insomnia, it is non-addictive and can safely be prescribed together with SSRIs used to treat depression and anxiety.

[11] Flexeril is the trade name for cyclobenzaprine, which is a muscle relaxant.

34. On March 17, 2015, Respondent saw Patient A for increased lower back pain and increased her Norco prescription. On March 30, 2015, Respondent saw Patient A for "...worsening LBP[12]– not sleeping well." Respondent documented the same findings for a back exam as previous visits and she started Patient A on tramadol. Respondent also documented the patient was "stressed" and "tired." Respondent documented in the treatment plan that they "...discussed sleep strategies. Alternate Soma and Flexeril." Respondent next saw Patient A on April 14, 2015, for a "recheck (of) LBP and (for) med refill." Respondent documented that Patient A's neck exam was, "normal ROM[13] no masses." Respondent documented that Patient A's back exam was "tightness of PVMs[14]" and the assessments are "low back pain, migraine headache, myalgia and myositis, insomnia and depressive disorder." Respondent did not document the status of Patient A's depression in the progress note. Respondent's plan was to start tramadol 50 mg. QID[15] #240 for acute pain, refill Norco 10/325 mg. one to two tabs orally QID. Respondent noted that on certain days the Patient could increase their Norco intake to six tabs per day.

35. On April 28, 2015, Respondent documented that she saw Patient A for pain and stress, and noted that after a minor car accident, Patient A's family attempted to admit her to a psychological unit and that they disposed of all Patient A's controlled substances. Respondent documented that Patient A needed early refills for Norco, tramadol, and Flexeril. An attached emergency room note from before April 28, 2015, stated that Patient A had come to the emergency room for mental health treatment and that her family was worried she was abusing her drugs. A urine drug screen performed in the emergency room indicated that Patient A was only positive for opiates, despite Respondent previously prescribing 30 carisoprodol on March 23, 2015, and April 22, 2015, to Patient A. In addition, Respondent documented that Patient A was seeing a psychiatrist and counselor for PTSD due to her stressful job as a law enforcement dispatcher. Respondent noted that her shift work and long hours were increasing her back pain

[12] Low Back Pain
[13] Range of Motion
[14] Perivertebral Muscles
[15] Four times daily

and that she had "inadequate pain relief". In direct contrast to those back pain findings, Respondent's physical examination documented "no apparent distress, ..., ambulatory,..." The assessments were the same from the previous visit. Respondent refilled Norco, Flexeril, and tramadol with a note of "will watch for opioid abuse. Recommended to pt(.) to have husband lock meds away from her & family – fill pill case one week at a time." On May 12, 2015, Patient A saw Respondent's supervising physician in clinic and stated her family, "stole her meds again."

36. On May 29, 2015, Respondent saw Patient A in clinic. Patient A reported that she used Norco at home and tramadol while at work. Respondent did not document if Patient A had any issues with anxiety. Respondent documented that Patient A did not think her Prozac was working well and that she was seeking a new psychiatrist. Respondent's documented assessments of Patient A were the exact same as previous visits but with the addition of "Generalized Anxiety Disorder" which was added to the records without explanation. Respondent refilled Norco and tramadol and she changed Prozac to Lexapro.[16] Respondent next saw Patient A on June 5, 2015, and documented "new onset of neck pain". Patient A reported that she had numbness to fingers, her chronic tension headaches were becoming more frequent, and she had trouble sleeping. Respondent ordered both an injection of Valium and some trigger point injections.

37. On June 10, 2015, Respondent documented that Patient A should taper her Topamax[17] because she was having word-finding difficulty and "decrease(d) cognitive sharpness." Respondent refilled Norco and tramadol. Respondent next saw Patient A on June 30, 2015. At that visit, Patient A reported that she was taking six and one quarter milligrams of Ambien at bedtime because trazodone did not work anymore. Respondent started Patient A on Ambien and ordered an injection of diazepam and trigger point injections. On July 7, 2015, Respondent documented that Patient A reported that her family disposed of her tramadol and gabapentin. Respondent entered into an agreement with Patient A where Patient agreed to weekly

[16] Escitalopram (Lexapro) is a selective serotonin reuptake inhibitor used to treat depression.

[17] Topiramate (Topamax) is an anticonvulsant used to treat seizures and can be used to treat headaches.

medication refill visits. Respondent prescribed tramadol and ordered a cervical spine x-ray and MRI. Respondent also referred Patient A to pain management for an occipital nerve block.

38. On July 15, 2015, Respondent documented that Patient A was now off work and that her headaches had improved. On July 22, 2015, Respondent documented that Patient A wanted to go back on trazodone because Ambien was not working. Respondent prescribed both trazodone and Ambien for insomnia. On August 12, 2015, Patient A reported that she was alternating between Ambien and trazodone and still having sleeping problems. Patient A stated she was in physical therapy and PTSD therapy. Respondent instructed Patient A to decrease her use of Norco 10/325 mg. from forty two pills to forty pills per week. On September 8, 2015, Respondent documented that Patient A reported that physical therapy was effective in reducing widespread muscle pain. On September 23, 2015, Respondent documented that Patient A reported that the frequency of headaches had decreased. Respondent started Patient A on Soma three times daily instead of Flexeril.

39. On October 13, 2015, Respondent saw Patient A in clinic. The HPI[18] portion of the chart was not updated and Respondent noted only that Patient A had constant low back pain. The rest of the note appears to be template from previous notes without clarifying information. The chief complaints were documented as "trigger points and occipital nerve block" and "7-day pain med refills." There was no interim update regarding the condition of Patient A's lower back pain or headaches. At that time, Respondent was prescribing a combination of Norco, tramadol, Ambien, and Soma to Patient A. Respondent began prescribing Valium 5 mg. twice daily as needed for spasm. Respondent refilled Norco and tramadol. Respondent did not document a discussion with Patient A regarding medication safety with regard to the multiple sedatives, which included opioids, benzodiazepines, and muscle relaxers, that Respondent was now prescribing to Patient A. In combination, these medications can lead to respiratory depression and death.

///

///

[18] History of present illness

40. Between January 2016 and June 2016, Respondent was prescribing three short-acting opioid prescriptions to Patient A including Tylenol # 4, Norco, and tramadol as well as Valium, Soma and Ambien. On January 27, 2016, Respondent documented that Patient A was "attempting to taper down on Norco very slowly. Pt now on 40 tabs per week." On June 6, 2016, Patient A called in seeking an early medication refill. Respondent refilled a two-day supply of Tylenol #4 and a nine-day supply of Valium stating, "I don't want (Person X) to have to deal w/ prescribing to pt. Her situation is a bit of a mess. (She took too many Tizanidine – 20 of them – for pain relief & went to the ER. Her family subsequently threw away ALL her meds (even the non-opiates.)" Respondent did not clarify the relationship between Person X and Patient A, nor did she explain a plan for Patient A's future chronic pain management care.

41. On June 8, 2016, Respondent saw Patient A in office. Respondent did not document any information regarding the above referenced medication overdose, the subsequent visit to Emergency Department that is described in the note, or how this information impacted Patient A's plan of care. Respondent prescribed antibiotics to Patient A for "acute sinusitis" but did not document a history of sinus symptoms. Respondent refilled Tylenol #4 and Norco. Respondent saw Patient A in office on July 19, 2016. Respondent began prescribing Dilaudid to Patient A. Respondent only mentioned Dilaudid at the end of the note by stating: "Follow Up: 1 Week (Reason: Med recheck – Dilaudid; check in on other meds.)" Despite prescribing an opioid pain medication in Dilaudid, which is four times more powerful than hydrocodone, Respondent failed to document why the Dilaudid was now being prescribed to Patient A.

42. On July 26, 2016, there is a telephone message documented in the medical chart that Patient A ran out of her medication a day early despite a previous early vacation refill. Respondent documented that Patient A needed to bring in all her meds at her next visit, presumably for a pill count. On August 2, 2016, Respondent documented that Patient A was placed on a trial of Dilaudid as a substitute for Norco. Patient A noted that the Dilaudid controlled her pain more effectively and that she had "fewer cognitive effects/sedation." The patient was instructed to stop Norco and take Dilaudid. Respondent still prescribed Tylenol # 4, Soma and tramadol. On August 16, 2016, Respondent documented that Patient A was doing

"really well" on Dilaudid. Respondent did not clarify that statement. Respondent refilled Dilaudid and Norco, despite noting on August 2, 2016, that Norco was actually planned to be stopped. Respondent documented that she told Patient A to stop taking Ultram and Tylenol #4.

43. On or about September 28, 2016, Respondent prescribed 20 mg. oxycodone to Patient A. On September 28, 2016, Respondent documented the same comment from August 2, 2016, that Dilaudid worked better than Norco. Respondent documented that she refilled Soma and Dilaudid and instructed Patient A to stop Norco. Respondent also documented that Patient A should start taking 20 mg. oxycodone at bedtime. On October 5, 2016, Respondent documented that Patient A was doing really well with Dilaudid during the daytime and Norco at bedtime despite just documenting at the visit before that she had instructed Patient A to stop taking Norco. Respondent documented a new plan where Patient A would take 4 mg. Dilaudid four times during the day and take 10 mg. oxycodone twice at night. On November 8, 2016, Respondent documented in the medical chart that Patient A was out of her Dilaudid because some of it "went down the sink." On November 16, 2016, Patient A was in clinic for a "med refill" but there were no other updates documented for that date, specifically any reference to the November 8, 2016, claim that Patient A's Dilaudid had gone down a sink. Respondent documented a new plan where Patient A would take Dilaudid 4 mg. three times during the day and then take 20 mg. Oxycodone three times a day.

44. A review of the complete medical records between February 25, 2015, and March 17, 2017, showed that Respondent's medical charting was sporadic. Respondent often failed to reconcile medication lists on a regular basis and it appeared that a copy forward function was used in the electronic medical records to duplicate information from previous visits without verifying if the information was accurate for the visit that was actually taking place. For example, in the notes Respondent would document that the patient was "doing better" on the same day as documenting that Patient A was still in the same constant pain that had been documented when treatment began. In addition, Respondent's medical records often did not match either the dispensing history in CURES or in the certified pharmacy profiles kept by the

///

various pharmacies. Respondent never documented a history or physical examination when she diagnosed "acute sinusitis" that would have supported the prescribing of antibiotics.

45. A review of the complete medical records showed that Respondent was often prescribing on a weekly schedule to help control Patient A's intake of controlled substances. However, Respondent failed to provide any significant clinical justification for increasing Patient A's morphine equivalent daily doses. Respondent's documentation that she was tapering Patient A's medication was misleading at best as the morphine equivalent daily doses remained static over time. In addition, Respondent stated justification for prescribing multiple short-acting opioid medications at the same time in order to "extend the dosing interval" was not clinically correct when prescribing the same number of other opioid pills on an on-going basis. Respondent never documented whether she provided important patient education to Patient A regarding the mixture of opioids and benzodiazepines and the risk of overdose and death that the combination of those medications pose despite repeated prescriptions of multiple short acting opioid medications in combinations with benzodiazepines, hypnotics, and sedatives. Despite Patient A having a history of overdose and medication mismanagement, Respondent did not insist on the regular use of urine drug screening and Respondent never sought additional medical records from Patient A's psychiatric and physical therapy visits.

46. Patient A also exhibited multiple instances where she showed high-risk behavior by losing medications, suffering overdoses, and having symptomology consistent with misuse. Respondent failed to refer Patient A to expert pain management consultation despite Patient A's recurrent, aberrant, drug-seeking behaviors with co-morbid mental health diagnoses. Respondent also failed to take into account Patient A's history of a suicide attempt by overdose. Instead, Respondent ignored the warning signs surrounding Patient A and continued to prescribe multiple long and short-acting opioids, mixed with benzodiazepines and additive muscle relaxers. Respondent did not document discussing Patient A's pain management treatment with her supervising physician. Respondent did not consult with any of Patient A's mental health providers about Patient A's pain management treatment.

///

47. Respondent failed to document whether she clarified Patient A's claim that Prozac was not working well. Respondent did not document whether Patient A was suffering from anxiety, depression, or something else. Respondent did not document any justification from changing Patient A from Prozac to Lexapro. Respondent did not document whether there was the presence or absence of medication side effects from these medications. Respondent added "Generalized Anxiety Disorder" to the patient's assessment list but made no mention of the basis for the diagnosis of anxiety in the notes. Respondent never documented following up with Patient A to verify if the Lexapro was more effective. Respondent never documented that she discussed Patient A's mental health treatment with any of Patient A's mental health providers or her supervising physician despite her continued treatment of Patient A's anxiety.

48. Respondent's license is subject to disciplinary action because she committed gross negligence during the care and treatment of Patient A in the following distinct and separate ways:

a. Inappropriately prescribing controlled substances to Patient A without sufficient medical justification, in the following, but not limited to, ways: by providing significant increases in morphine equivalent dosage without medical justification and/or documenting medical justification; by failing to provide and/or document providing important patient education regarding the risks of taking opioids and benzodiazepines at the same time; by failing to treat Patient A as a high risk patient who was susceptible to overdose, and, by failing to discuss and/or failing to document that she discussed Patient A's care with her supervising physician; and,

b. Failing to appropriately evaluate and manage a patient with anxiety disorder.

Patient B

49. Between December 4, 2015, and February 15, 2017, Respondent prescribed the following controlled substances including, but not limited to, carisoprodol, Norco, Ultram, Klonopin, Dilaudid, and Percocet to Patient B. In addition, by April 2017, Respondent began prescribing Fentanyl and lorazepam to Patient B. By way of example, the following prescriptions were written by Respondent and filled by Patient B, between October 9, 2015, and November 26, 2015.

Date Prescription Filled	Type of Prescription	Dosage of Prescription	Quantity of Prescription	Schedule of Prescription	Refills
10/9/2015	Norco	10/325 mg.	240 TAB	II	0
10/13/2015	Soma	350 mg.	90 TAB	IV	yes
10/28/2015	Norco	10/325 mg.	240 TAB	II	0
11/10/2015	Soma	350 mg.	90 TAB	IV	Yes
11/19/2015	Ultram	50 mg.	90 TAB	IV	0
11/19/2015	Klonopin	.5 mg.	50 TAB	IV	0

50. Between October 9, 2015, and November 26, 2016, in a period of 48 days, Respondent prescribed, and Patient B filled, prescriptions for 480 pills of Norco, 180 pills of Soma, 50 pills of Klonopin, and 90 pills of tramadol. At that time, the morphine equivalent dose per day was 109 from these two short acting opioid medications while Respondent was also prescribing a muscle relaxer and a benzodiazepine to Patient B.

51. By way of example, the following prescriptions were written by Respondent and filled by Patient B, between October 1, 2016, and December 15, 2016.

Date Prescription Filled	Type of Prescription	Dosage of Prescription	Quantity of Prescription	Schedule of Prescription	Refills
10/1/2016	Percocet	10/325 mg.	240 TAB	II	0
10/2/2016	Soma	350 mg.	90 TAB	IV	yes
10/25/2016	Soma	350 mg.	90 TAB	IV	Yes
10/25/2016	Dilaudid	4 mg.	90 TAB	II	0
10/25/2016	Klonopin	.5 mg.	60 TAB	IV	0
10/31/2016	Percocet	10/325 mg.	180 TAB	II	0
11/15/2016	Dilaudid	4 mg.	90 TAB	II	0
11/17/2016	Percocet	10/325 mg.	240 TAB	II	0

11/22/2016	Soma	350 mg.	90 TAB	IV	0
12/9/2016	Klonopin	.5 mg.	60 TAB	IV	0

52. Between October 1, 2016, and December 15, 2016, in a period of 76 days, Respondent prescribed, and Patient B filled, prescriptions for 660 pills of Percocet, 180 pills of Dilaudid, 270 pills of Soma, 120 pills of Klonopin. At that time, the morphine equivalent daily dose was 165 while Respondent was also prescribing a muscle relaxer and a benzodiazepine to Patient B.

53. On or about December 5, 2014, Respondent began providing care to Patient B. Respondent documented that Patient B was a new patient who was there to establish care and had complaints including, but not limited to, chronic knee pain, LBP, "Abd(.)[19] pain", and she required screening for various women's health related concerns. Patient B complained that she had "chronic knee pain – had 4 knee surgeries – M/C[20] accident 2000" and dealt with concussions from multiple traumas. Respondent documented vital signs but she did not document any physical examination findings. Respondent assessed that Patient B had the following, but not limited to, ailments, which included abdominal pain, muscle spasm of the back, chronic LBP, and chronic knee pain. Respondent's plan included referring Patient B to GI[21] for a colonoscopy, prescribing Soma for back spasms, and prescribing Norco as needed, "for chronic knee pain due to severe OA[22]." Respondent did not document whether she ordered any testing to verify her assessments related to Patient B's back or knee pain.

54. Respondent next saw Patient B on December 26, 2014. Respondent failed to document an update of Patient B's medical history regarding her painful conditions. Respondent documented a normal back examination. Respondent refilled Patient B's Norco prescription. After a series of follow-ups, on March 3, 2015, Respondent documented additional information related to Patient B's knee pain. Respondent noted that Patient B has knee pain, "with swelling, with walking, with flexion, constant pain." That history was then copied word-for-word into

---

[19] Abdominal
[20] Motorcycle
[21] Gastroenterology
[22] osteoarthritis

additional follow-up notes, including March 24, 2015, and April 17, 2015, without additional changes or clarifications.

55. On August 28, 2015, Respondent documented a social history and noted that Patient B reported she drank one to two alcoholic beverages, four or more times per week. At that time, Respondent was prescribing Norco and Soma to Patient B. Respondent did not document that she provided advice and/or information to Patient B regarding whether or not it was advisable to be drinking alcohol while on controlled substances.

56. On November 19, 2015, Respondent documented that she saw Patient B for a chief complaint of "med. refills and depression." Respondent noted that "patient here with increasing pain due to colder/wetter weather. Pt. also has a mentally ill daughter who is abusive and out of control. – this is causing pt. a lot of anxiety & depressed mood." According to Respondent, Patient B reported worsening panic attacks, worsening stressors, minimal support, no counseling, insomnia and decreased energy. Respondent documented that Patient B denied seeing a counselor or psychiatrist. Respondent documented that Patient B's alcohol screening was positive and the medication list continued to include Norco and Soma. Respondent also began prescribing tramadol, a second short-acting opioid, for "breakthrough" pain to Patient B. Respondent prescribed Celexa[23] and Klonopin to Patient B. Respondent did not document providing Patient B with a mental health referral. Respondent did not document providing Patient B with informed consent regarding the concomitant use of opioids with benzodiazepines. Respondent did not document that she counseled Patient B regarding the dangers of alcohol use while taking controlled substances. Finally, the medical record at that time showed that right and left knee x-rays performed on Patient B had been read as normal on November 3, 2015.

57. On December 17, 2015, Respondent documented that Patient B did not pick up the Celexa because she was able to, "talk it out with family and friends." Respondent documented that Klonopin was continued despite Patient B's ability to "talk it out with friends". Respondent also continued to document that Patient B should "Start citalopram" for adjustment disorder with

[23] Celexa (citalopram) is an antidepressant that is from the selective serotonin reuptake inhibitor class of medications.

depressed mood but did not document whether she had counseled Patient B regarding whether she should pick up the medication after Patient B stated she did not pick up the Celexa after the last appointment. On February 19, 2016, Respondent documented that, "Pt here for f/u chronic knee & foot pain, pain med refills, anxiety, and depressed mood. Meds helping with anxiety." Respondent did not document any other updates and continued all of Patient B's medications. Respondent documented "Start Celexa" without clarification to previous visits where she had already started the medication. In addition, on this date, Respondent prescribed pramipexole[24] for "restless legs" but Respondent provided no documentation to support that assessment.

58. On March 23, 2016, Respondent documented the chief complaint as "needs more Celexa." The medication list stated that Patient B was taking Celexa but the plan still read, "start Celexa." Respondent documented in the note that the patient could not tolerate Celexa and then copied that the patient could not tolerate Celexa forward in subsequent progress notes where the medication list specifically stated that the patient was taking Celexa. Respondent also documented that Patient B could not take pramipexole because it, "gave her bizarre dreams and made her feel weird." On April 19, 2016, Respondent documented that Patient B should "start pramipexole" in spite of the note documented on March 23, 2016.

59. On June 8, 2016, Respondent saw Patient B for chronic foot and bilateral knee pain. There is no documentation regarding whether or not Patient B's conditions had changed or worsened. Respondent continued to prescribe Norco and began prescribing Dilaudid for "severe breakthrough pain" despite not justifying a need in the chart to start Dilaudid. On August 2, 2016, Respondent documented that Patient B had suffered a new stress fracture in her foot. Respondent stopped prescribing Norco and began prescribing Percocet. Respondent increased Patient B's Dilaudid prescription. Respondent continued to prescribe Soma and Klonopin. Respondent continued to document that Patient B consumed alcohol while receiving controlled substance prescriptions. On September 1, 2016, Respondent documented that Patient B was "newly postop" from foot surgery. On October 25, 2016, Respondent again documented that

[24] Pramipexole (Mirapex) is a medication used to treat Parkinson's disease and restless leg syndrome.

Patient B was "newly postop" from foot surgery and that the plan was to taper down Dilaudid next month. On November 15, 2016, Respondent again documented that Patient B was "newly postop" from foot surgery and that the plan was to taper down Dilaudid next month. On December 16, 2016, Respondent documented that Patient B was in severe pain due to a complication from foot surgery.

60. On February 7, 2017, Respondent documented that Patient B was hoping to taper her Dilaudid for her postoperative pain. At that time, Patient B was taking, per day, eight Percocet 10/325 mg. plus a total of 4 mg. of Dilaudid for breakthrough pain. Respondent referred Patient B to Physical Medicine and Rehabilitation on this date. Respondent finally documented that she provided counseling to Patient B regarding the dangers of unhealthy alcohol use. Respondent documented a physical therapy consultation on April 3, 2017, for right shoulder pain and weakness.

61. On April 5, 2017, Respondent documented that Patient B was having trouble with tapering down on pain meds and noted that Patient B had trouble with medication overuse in the past. Respondent noted that Patient B was suffering from withdrawal symptoms. Respondent stopped Patient B's Percocet prescription due to concerns with "Tylenol excess." Respondent began prescribing short-acting oxycodone 20 mg. and provided a one-week prescription of 35 pills.[25] On April 12, 2017, Respondent ordered a urine drug screen. On April 13, 2017, that drug screen was negative for opiates and benzodiazepines despite Respondent previously prescribing Percocet, Dilaudid and clonazepam. On April 17, 2017, Patient B called and reported to Respondent's medical clinic she had again suffered a broken toe. On April 19, 2017, Respondent saw Patient B in her medical clinic and Patient B reported that she was having withdrawal symptoms and that clonazepam was not helping with her withdrawal symptoms. Respondent documented that Patient B reported oxycodone was not helping with her pain, as Patient B stated it remained eight to nine on a pain scale of ten. Respondent did not order x-rays and diagnosed Patient B with a fracture of right foot. Respondent did not document whether she discussed

[25] MED of 150.

Patient B's negative urine test from April 12, 2017. Respondent started Patient B on 25 mcg./hr. Fentanyl patches and refilled her 20 mg. oxycodone prescription.[26] Respondent continued to prescribe 1.5 mg. of lorazepam and failed to document whether or not she warned Patient B of the dangers of concomitant Fentanyl, oxycodone and benzodiazepine use.

62. On April 26, 2017, Respondent stopped the Fentanyl patches and 20 mg. oxycodone tablets and began prescribing one 30 mg. oxycodone tablet every six hours.[27] On April 26, 2017, a urine test performed on Patient B revealed that she continued to test negative for opiates and benzodiazepines despite previously being prescribed multiple opiates and benzodiazepines on April 19, 2017.

63. A review of Respondent's medical records kept for Patient B between December 4, 2015, and April 26, 2017, showed multiple inaccurate and conflicting statements. For example, it was impossible to determine upon a review of Respondent's multiple treatment plans for Patient B on how she was treating anxiety, on how she was using the anti-depression drug Celexa, or how she was using the restless leg medication, pramipexole. The medical records kept for Patient B, and the medication lists contained within, were often inconsistent with the prescribed medications. In addition, Respondent failed to obtain any medical records that pre-dated Respondent's treatment of Patient B to help Respondent explain Patient B's complex trauma, surgical, and pain history. Despite on-going changes in Patient B's care, Respondent often duplicated medical information from previous progress notes word-for-word without adding pertinent information.

64. A review of the treatment records showed that Respondent repeatedly prescribed controlled substances to Patient B. There was no documentation to justify the prescriptions. Respondent did not verify Patient B's knee pain history with outside records or require re-imaging of Patient B's condition. Respondent did not document a baseline level of functioning, nor did she document the non-opioid therapies that Patient B may or may not have attempted prior to starting opioid therapy. Instead, Respondent repeatedly combined a habit forming muscle

[26] 210 MED. 1 25 mcg./hr. Fentanyl transdermal patch and 7 20 mg. oxycodone tablets.

[27] She actually prescribed 34 pills for seven days, or approximately 5 pills a day. 150 mg. of oxycodone has an MED of 225.

relaxer with opioids. Respondent made no attempt to use less habit-forming agents and she did not document her clinical decision making process in Patient B's medical records. Respondent did not document obtaining informed consent when she began treating Patient B with controlled substances nor did she document obtaining informed consent as she changed Patient B's opioid prescriptions to medications that were more powerful. Respondent failed to document whether she ever warned Patient B of the significant risk of mixing alcohol, benzodiazepines and opiates. Respondent never documented that she advised Patient B to stop drinking while taking controlled substance or required Patient B to stop drinking as part of her pain management care.

65. Respondent failed to perform comprehensive pain assessments. For example, in June 2016 Respondent increased Patient B's daily morphine equivalents by adding Dilaudid 2 mg. for "severe breakthrough pain" but failed to provide a comprehensive pain assessment in the history of present illness to justify the addition of Dilaudid to Patient B's pain management regimen. Respondent ordered an MRI of Patient B's knee at the June 2016 visit but failed to document whether she followed-up with the patient to see if the MRI was completed. Also by way of example, in August 2016, Respondent discontinued Norco, began Patient B on Percocet, and doubled Patient B's Dilaudid prescription while, continuing to prescribe Soma and Klonopin. Respondent increased Patient B's daily morphine equivalent dose in response to an injury reported by the patient without any objective findings. Respondent also ignored potential warning signs that were apparent during Patient B's chronic pain management treatment. For example, in April 2017 Patient B reported withdrawal symptoms and Respondent noted that she was taking an excessive amount of Percocet. At the same time, Respondent received a result from a urine drug screen that indicated Patient B was not taking controlled substances as prescribed. Respondent ignored the results of the negative drug screen, and instead documented that she added stronger opioid medications and benzodiazepines to Patient B's pain management regimen.

66. Respondent failed to properly titrate controlled substances to treat Patient B's complaint of depression and anxiety. Respondent did not use a validated diagnostic instrument such as a PHQ-9. Respondent prescribed a benzodiazepine at the same time that she was

prescribing Celexa without first trying to see if a non-controlled substance by itself would be effective for anxiety. Respondent also initially prescribed benzodiazepines at a rate of two times a day when a safer starting frequency would have been one time a day. Finally, as noted above, Respondent never documented discussing the dangers of using opiates with benzodiazepines, especially in light of Patient B's positive alcohol screenings.

67. Respondent failed to properly evaluate Patient B's knee pain and mechanical symptoms. A review of Patient B's medical record shows that Respondent did not document a knee physical examination, and did not perform on-going repeat examinations of Patient B's knee. In addition, Respondent never attempted to obtain outside medical records related to Patient B's knee conditions. Respondent never documented performing more conservative knee treatments such as bracing, icing, NSAIDS, or physical therapy prior to starting controlled substances. Respondent rarely ordered knee x-rays to gain clarity on Patient B's condition. Respondent did not offer braces, crutches or an orthopedic surgery consultation when Patient B reported mechanical symptoms caused by her knees.

68. Respondent's license is subject to disciplinary action because she committed gross negligence during the care and treatment of Patient B in the following distinct and separate ways:

a. Inappropriately prescribing controlled substances to Patient B without sufficient medical justification in the following, but not limited to, ways: by failing to and/or document failing to verify if Patient B had a knee condition that justified controlled substances; by failing to and/or document failing to perform initial physical examinations before prescribing controlled substances; by failing to use less-habit forming agents when she began to initially prescribe to Patient B; by providing significant increases in morphine equivalent dosage without documenting medical justification; by failing to provide and/or document whether she provided important patient education regarding the risks posed by mixing alcohol, opioids, and benzodiazepines, and, by failing to and/or document failing to seek out consultation from an outside pain expert;

b. Failing to appropriately evaluate and manage Patient B's anxiety disorder; and,

c. Failing to evaluate and treat Patient B's knee pain and mechanical symptoms.

Patient C

69. On or between January 29, 2014, and July 6, 2016, Respondent prescribed a combination of morphine sulfate, methadone, lorazepam, and diazepam to Patient C. During the same time, Respondent's supervisor also provided pain management care to Patient C. By way of example, on February 27, 2015, Respondent provided a one-month supply of controlled substances to Patient C by prescribing 90 tablets of 30 mg. morphine sulfate and 120 tablets of 2 mg. lorazepam. Respondent continued to prescribe lorazepam to Patient C on a regular basis as well as refilling his morphine sulfate in March of 2015. At that time, Patient C was receiving a daily dose of 90 MED from the morphine while he was also taking a benzodiazepine. By way of example, on July 24, 2015, Respondent provided a one-month supply of controlled substances to Patient C when she prescribed 270 10 mg. tablets of methadone and lorazepam. At that time, Patient C was receiving a daily dose of 1080 MED from the methadone (90 mg. multiplied by a factor of 12) while he was also taking a benzodiazepine.

70. The following medical records contain entries prior to January 29, 2014, which are relevant to Respondent's later care and treatment of Patient C. First, on October 15, 2006, an MRI of Patient C's lumbosacral spine showed an intervertebral disc extrusion at the L5-S1 level without a mass effect on the adjacent nerve roots. There was a mild to moderate neural foraminal narrowing at that level. On June 22, 2007, a follow-up MRI of the lumbar spine showed a marked reduction in the size of the disc protrusion from the October 15, 2006 MRI. On March 8, 2011, Patient C was diagnosed with severe obstructive sleep apnea. On July 29, 2013, Patient C signed a controlled substances treatment agreement with Respondent's supervising physician.

71. On April 24, 2014, Respondent's supervising physician changed Patient C's diagnosis of ankylosing spondylitis to "chronic pain syndrome." On May 16, 2014, Respondent saw Patient C in clinic and noted he was taking three tablets of 30 mg. morphine sulfate daily, "very responsibly." Respondent noted that Patient C complained of right shoulder and right arm pain.

72. On June 9, 2014, a pain management specialist saw Patient C for a pain management consultation. The pain management specialist noted that Patient C tested positive for marijuana, oxycodone, benzodiazepines, and opioids despite Patient C's statement to the specialist that he

was only taking 3 tablets of 30 mg. morphine sulfate per day at that time. Patient C admitted that he used to drink alcohol heavily and that he had a past arrest for driving under the influence. Patient C stated he stopped drinking in 2007 but that this led to a rapid escalation in opioid use. The pain management specialist noted that Patient C appeared overmedicated or intoxicated at the treatment visit and the specialist concluded that Patient C was not a good candidate for opioid therapy. On June 21, 2014, a spine surgeon diagnosed Patient C with post-laminectomy syndrome and noted that Patient C did not meet criteria to diagnose ankylosing spondylitis as had been previously suspected.

73. On August 13, 2014, Respondent saw Patient C for a medication review. Respondent did not document a specific history of present illness, and did not document a specific back examination. Respondent noted that Patient C's gait was normal and he had some shoulder pain. Respondent listed ankylosing spondylitis on the list of assessments. Respondent refilled Patient C's morphine sulfate prescription. Respondent did not document incorporating the pain medicine specialist's consultation in her treatment plan for Patient C.

74. On January 2, 2015, Respondent saw Patient C in clinic for refills of lorazepam and morphine. Respondent documented that Patient C had seen a psychiatrist and that his back, shoulder and neck pain remained unchanged. The plan both mentioned that Respondent was to "start" Patient C on 2 mg. lorazepam, four times a day while also continuing lorazepam for anxiety. On May 15, 2015, Respondent's supervising physician converted Patient C from morphine sulfate to OxyContin due to uncontrolled pain. On or about July 2, 2015, Respondent's supervising physician converted Patient C from OxyContin to methadone and prescribed 30 mg. three times daily.

75. On July 24, 2015, Respondent saw Patient C for various complaints including follow-up and spinal x-ray. Respondent included ankylosing spondylitis in Patient C's history. Respondent noted that Patient C's alcohol screening was positive. Respondent noted that the medication list "was reviewed and reconciled with the patient" but documented that the status of Patient C's OxyContin prescription, morphine prescription and lorazepam prescription were unknown. The note also indicated that the Patient was taking diazepam. Respondent documented

in the section entitled "Plan" that Patient C's methadone was to be refilled with a one-month prescription of 270 10 mg. tablets and she refilled his diazepam prescription.

76. On February 16, 2016, Respondent documented that she saw Patient C in clinic and she noted he was taking 2 mg. of lorazepam four times daily, one half to one tablet of 10 mg. diazepam up to three times daily and taking three tablets of 10 mg. methadone every 8 hours. Respondent refilled the methadone and lorazepam but did not mention the diazepam in her plan. On March 15, 2016, Respondent's supervising physician documented that Patient C's methadone and lorazepam dosages needed to be tapered at follow-up visits. On March 24, 2016, Respondent's supervising physician documented an addendum that Patient C had not received diazepam in over a year. As noted above, Respondent had prescribed diazepam in July 2015.

77. On April 13, 2016, Respondent saw Patient C in clinic. Respondent refilled Patient C's methadone and lorazepam prescriptions as previously prescribed despite Respondent's supervisor noting on March 15, 2016, that both prescriptions needed to be tapered. Respondent documented that Patient C's medications were to be tapered per her supervising physician as of March 15, 2016, but did not document if she discussed Patient C's medication plan with her supervising physician prior to refilling his prescriptions as he had previously been prescribed. On May 9, 2016, Patient C contacted the clinic and stated that he had not seen his psychiatrist in some time and that his psychiatrist would not refill his psychiatric medications.[28] Respondent's supervisor refilled Patient C's five separate psychiatric medications.

78. On May 11, 2016, Respondent saw Patient C in clinic for follow-up related to chronic pain and for medication refills. Respondent refilled Patient C's methadone and lorazepam prescriptions as previously prescribed despite Respondent's supervisor noting on March 15, 2016, that both prescriptions needed to be tapered. Respondent documented that Patient C's medications were to be tapered as of March 15, 2016, per her supervisor's previous note, but did not document if she discussed Patient C's medication plan with her supervising physician prior to

[28] It appears from a review of the records that during Respondent's care of Patient C, he was often living in Reno, Nevada and may have been filling his controlled substance prescriptions out-of-state. These prescriptions would not have been recorded by CURES.

refilling Patient C's prescriptions as previously prescribed. Respondent also documented that she would "refill diazepam, 10 mg., half to one tablet, up to three times a day."

79. On June 8, 2016, Respondent saw Patient C in clinic for follow-up. Respondent refilled Patient C's methadone and lorazepam prescriptions as previously prescribed despite Respondent's supervisor noting on March 15, 2016, that both prescriptions needed to be tapered. Respondent documented that Patient C's lorazepam was to be tapered as of March 15, 2016, but did not document if she discussed Patient C's medication plan with her supervising physician prior to refilling his prescriptions as previously prescribed. Respondent refilled Patient C's prescriptions at the same doses of methadone, lorazepam, and diazepam according to the progress note.

80. On August 3, 2016, Respondent saw Patient C in clinic for a medication refill. Respondent documented that Patient C had not been seeing a psychiatrist since moving to Reno a number of months ago. Respondent documented that Patient C was going to arrange to see a psychiatrist. Respondent documented that she refilled Patient C's four separate psychiatric medications and refilled his methadone, diazepam, and lorazepam as previously prescribed. The progress note still contained an entry to taper lorazepam as of March 15, 2016. On August 31, 2016, Patient C saw Respondent for follow-up, medication refills, and the completion of Department of Motor Vehicle Forms. Respondent noted that Patient C was still not seeing a psychiatrist. Respondent documented that she refilled Patient C's methadone, lorazepam, and diazepam. She also refilled his psychiatric medications. Respondent also entered ankylosing spondylitis in Patient C's plan despite that diagnosis being previously ruled out.

81. A review of Respondent's medical records kept for Patient C between January 29, 2014, and August 31, 2016, shows that the records were not accurate. Respondent continued to document that Patient C suffered from ankylosing spondylitis despite the June 2014 consultation with a specialist that ruled this condition out. In January 2015, Respondent noted that she was both starting and continuing lorazepam at the same time. In addition, Respondent's notes were unclear regarding when or when she was not prescribing both lorazepam and diazepam to Patient C. Respondent continued to document in subsequent progress notes that the plan was to taper

lorazepam and methadone but she never instituted that plan or documented why she was not starting to taper controlled substances. Finally, Respondent did not document performing examinations of Patient C's back, which resulted in a lack of clarity regarding whether his pain conditions were actually being treated effectively.

82. A review of the Respondent's medical records kept for Patient C between January 29, 2014, and August 31, 2016, show that Respondent failed to document updates of Patient C's painful conditions, his activity level, whether or not he was suffering from side effects, and physical examinations of painful conditions that would justify high doses of pain medications mixed with benzodiazepines. Respondent also failed to justify whether or not chronic pain management therapy was leading to functional improvements in Patient C's life.

83. Respondent failed to account for the conclusions of the pain management consultation completed on or about June 9, 2014, during her chronic pain management treatment of Patient C. Despite a specialist's finding that Patient C was a very high-risk patient who was not a good candidate for opioid therapy, Respondent continued to prescribe high doses of methadone mixed with benzodiazepines to Patient C. Respondent's documentation appears to ignore Patient C's history of alcohol use and his previous diagnosis of obstructive sleep apnea. Respondent's treatment of Patient C placed him at a high risk of overdose and death. Respondent also failed to justify why she was not following her own supervising physician's plan to taper Patient C's prescriptions of methadone and lorazepam. A review of the records also showed that Respondent failed to use urine drug screenings when treating Patient C despite his admitted history of dishonesty regarding his issues with past substance abuse. Respondent failed to order an electrocardiogram (EKG) on Patient C before prescribing methadone. Respondent also continued to prescribe methadone and benzodiazepines to Patient C after learning that a psychiatrist was not actively supervising Patient C.

84. Respondent's license is subject to disciplinary action because she committed gross negligence during the care and treatment of Patient C in the following distinct and separate ways:

a. Inappropriately prescribing controlled substances to Patient C without sufficient medical justification in the following, but not limited to, ways: by failing to document regular

updates in the patient's painful conditions, by failing to document on-going physical examinations that would justify the continued prescription of high doses of opioid pain medications mixed with benzodiazepines; and by failing to adopt and/or document adopting the recommendations of the pain management expert who had previously stated Patient C was not a good candidate for opioid therapy; and,

b. Prescribing high quantities of methadone to Patient C in a such a way to that placed him at risk of overdose and death.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

85. Respondent's license is subject to disciplinary action under sections 2234, subdivision (c), 3527, and 3528 in that she committed repeated negligent acts during the care and treatment of Patients A, B, C, and D. The circumstances are as follows:

86. Complainant realleges paragraphs 28 through 84, and those paragraphs are incorporated by reference as if fully set forth herein.

Patient D

87. Between May 22, 2013, and March 19, 2014, and February 20, 2015, and October 26, 2016, Respondent prescribed a combination of controlled substances to Patient D including, but not limited to, Norco, Ativan, Klonopin, Ultram, Tylenol #3, and Tylenol #4. Between March 19, 2014, and February 20, 2015, Respondent's supervising physician predominantly prescribed to Patient D. Respondent documented in-person office visits with Patient D on the following dates: May 22, 2013, June 13, 2013, August 9, 2013, September 4, 2013, February 20, 2015, April 10, 2015, December 17, 2015, March 25, 2016, and June 17, 2016. On or about August 14, 2016, Respondent's supervising physician discharged Patient D from the practice due to a "breakdown of trust."

88. On or about October 10, 2014, Patient D signed a controlled substance treatment agreement with Respondent's supervising physician. On May 22, 2013, Respondent documented a history and physical examination prior to initiating controlled substance therapy. Respondent noted that Patient D suffered from chronic neck, shoulder, and back pain. She noted that he had

an abnormal MRI result which had come from a test completed at Kaiser Permanente. Respondent also documented that Patient D took Ativan for anxiety.

89. A review of Respondent's medical charting for Patient D shows that Respondent properly documented Patient D's prescriptions, the justification for medication changes, and she documented that she provided explicit instructions to Patient D regarding the use of benzodiazepines. However, Respondent failed to order and/or document ordering urine drug screens during Patient D's treatment. Respondent also failed to review and/or document reviewing whether she checked the CURES database to determine if Patient D was misusing the medications that she prescribed. Respondent failed to perform and/or document performing on-going assessments of Patient D's functional status. Respondent failed to document what activities that Patient D was able to participate in as a result of on-going opioid therapy and whether or not the pain management regimen was effective or not. Respondent failed to document whether clinical goals were being met in a way that would support Patient D's on-going opioid therapy.

90. Respondent committed the following negligent acts during the care and treatment of Patients A, B, C, and D:

a.) Respondent inappropriately prescribed controlled substances to Patient A, who exhibited clear warning signs of abuse, in the following, but not limited to, ways: by providing significant increases in morphine equivalent dosage without documenting medical justification; by failing to provide and/or document providing important patient education regarding the risks of taking opioids and benzodiazepines at the same time; by failing to treat Patient A as a high risk patient; by failing to discuss and/or document discussing Patient A's care with her supervising physician;

b.) Respondent failed to appropriately evaluate and manage Patient A's anxiety disorder;

c.) Respondent inappropriately prescribed controlled substances to Patient B in the following, but not limited to, ways: by failing to verify if and/or document verifying if Patient B had a knee condition that justified controlled substances;

by failing to perform and/or document performing an initial physical examination before prescribing controlled substances; by failing to use less-habit forming agents when she began to initial prescribe medications; by providing significant increases in morphine equivalent dosage without medical justification; by failing to provide and/or document providing important patient education regarding the risks posed by mixing alcohol, opioids, and benzodiazepines; by failing to seek and/or document seeking a consultation from an outside pain expert;

d.) Respondent failed to appropriately evaluate and manage and/or failed to document evaluating or managing Patient B's anxiety disorder;

e.) Respondent failed to evaluate, treat, and document Patient B's knee pain and mechanical symptoms;

f.) Respondent inappropriately prescribed controlled substances to Patient C without sufficient medical justification in the following, but not limit to, ways: by failing to document regular updates in the patient's painful conditions; by failing to document on-going physical examinations that would justify the continued prescription of high doses of opioid pain medications mixed with benzodiazepines; by failing to adopt and/or document the adopting of the recommendations of the pain management expert who had previously stated Patient C was not a good candidate for opioid therapy;

g.) Respondent prescribed high quantities of methadone to Patient C in such a way to place him at risk of overdose and death; and,

h.) Respondent prescribed controlled substances to Patient D without documenting on-going assessments, including noting clinical goals and outcomes that would justify the on-going use of opioid analgesics.

///

///

///

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Record Keeping)

91. Respondent's license is subject to disciplinary action under section 2266 in that she failed to keep accurate and adequate medical records during her care and treatment of Patients A, B, C, and D. The circumstances are as follows:

92. Complainant realleges paragraphs 28 through 84, and 87 through 90 and those paragraphs are incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Controlled Substances without Examination and Indication)

93. Respondent's license is subject to disciplinary action under sections 2242, 3527, and 3528 of the Code in that she prescribed controlled substances without examination and indication during her care and treatment of Patients A, B, and, C. The circumstances are as follows:

94. Complainant realleges paragraphs 28 through 84, and those paragraphs are incorporated by reference as if fully set forth herein.

///

///

///

///

///

///

///

///

///

///

///

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

1. Revoking or suspending Physician Assistant License Number PA 21808, issued to Lisa Marie Gail, P.A.;

2. Ordering Lisa Marie Gail, P.A. to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Ordering Lisa Marie Gail, P.A. to pay the Physician Assistant Board the reasonable costs of probation if her license is revoked and the revocation is stayed and her license is placed on probation; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: August 2, 2019

MAUREEN L. FORSYTH
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

SA2018102424
Gail Accusation as of 7.24.docx